

TN

Application for Health Coverage & Help Paying Costs – Extra Pages for Additional Family Members

Please print in capital letters using black or dark blue ink only. Check the boxes (☐) like this. ☒

Use these pages if you have more than 2 people in your family applying for TennCare, CoverKids, or a Medicare Savings Program, like QMB/SLMB. **Before getting started, make copies of these pages for each additional person in your family.**

STEP 1: Person 1 This is the person you listed as PERSON 1 on your Application.

PERSON 1 is the Head of Household on your Application.

1. First name _____ Middle name _____ Last name _____ Suffix (Jr., Sr., III) _____
2. Social Security Number: ____ - ____ - _____

STEP 2: Tell us about other people who live with you.

Complete Step 2 for each additional person in your family.

If you have more people in your family, you'll need to make a copy of the pages and attach them. Or, you can print them from our website at www.tn.gov/tenncare.

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for health coverage.

When you send us your Application and these pages, be sure to send us proof of your income. This could be things like pay stubs or bank statements. Having this proof may help us decide faster if you get coverage with us.



STEP 2: Additional Family Member

Tell us about your additional family member(s).

Complete Step 2 for other family members who live with you. This includes anyone on your same federal tax return (if you file one). If you don't file a tax return, remember to still add family members who live with you.

1. First name	Middle name	Last name	Suffix
2. Date of birth (mm/dd/yyyy)		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Relationship to Person 1

5. **Social Security Number (SSN)** ____ - ____ - ____ If not, what date did you apply for one? _____

We need a Social Security number (SSN) if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. If you need help getting an SSN, visit [socialsecurity.gov](https://www.socialsecurity.gov), or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

6. Is this person applying for health coverage with us? ☐ Yes ☐ No

7. **If Hispanic/Latino, ethnicity (Optional – Check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

8. **Race (OPTIONAL – Check all that apply.)**

<input type="checkbox"/> White	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other _____
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	
	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Guamanian or Chamorro	
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Samoan	

9. Has PERSON 2 ever been known by any other name? **If yes:**

First name	Middle initial	Last name	Suffix
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10. If you are approved for TennCare Medicaid, there are three health plans to choose from. We'll try to enroll you in the health plan you choose. If you don't pick now, we can pick one for you. Usually, family members are enrolled in the same health plan. Please choose the same health plan for each person on this application. **I want my health plan to be:** ☐ AMERIGROUP ☐ BlueCare ☐ UnitedHealth Care Community Plan

If you are approved for CoverKids, your health plan will be Blue Care.

11. Is PERSON 2 a Tennessee resident? ☐ Yes ☐ No

12. Is PERSON 2 temporarily living out of state?

If Yes, does PERSON 2 plan to return to Tennessee? ☐ Yes ☐ No Date PERSON 2 plans to return to Tennessee: _____ (mm/dd/yyyy)

13. If PERSON 2 is younger than 22 years old, what is their school enrollment status? Skip this question if PERSON 2 is age 22 or older.

☐ None ☐ Less than 6 hours a week ☐ 6 or 7 hours a week ☐ 8 to 11 hours a week ☐ 12 or more hours a week (full time)

14. If PERSON 2 is younger than 22 years old, does PERSON 2 work full time? ☐ Yes ☐ No Skip this question if PERSON 2 is age 22 or older.

15. Is PERSON 2 a **U.S. citizen** or **U.S. national**? ☐ Yes ☐ No If yes, skip 16-22.

16. Is PERSON 2 a naturalized or derived citizen? ☐ Yes ☐ No If yes, provide answers to a. and b.

a. Alien Number: _____ b. Certificate Number: _____

17. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status? ☐ YES.

a. What is their immigration status? _____

What date did they gain that status? _____

Fill in Person 2's document type and ID number below. Document Type:

<input type="checkbox"/> Alien Number	<input type="checkbox"/> I-94 Number	<input type="checkbox"/> Card Number	<input type="checkbox"/> Passport Number
<input type="checkbox"/> SEVIS ID	<input type="checkbox"/> Certificate of Citizenship Number	<input type="checkbox"/> Naturalization Certificate Number	<input type="checkbox"/> Visa Number

ID Number: _____ Expiration date: _____ (mm/dd/yyyy)

b. Did they have a different immigration status before? ☐ Yes ☐ No

c. Have they lived in the U.S. since 1996? ☐ Yes ☐ No

18. Is PERSON 2, or PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19. If PERSON 2 is American Indian or Alaska Native answer 20-22. If not, skip 20-22.

20. Is PERSON 2 a member of a federally recognized tribe? ☐ Yes ☐ No **If Yes,** what is the name of the tribe? _____

21. Has PERSON 2 ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program, or through referral of one of these? ☐ Yes ☐ No

22. Is PERSON 2 eligible to get services from the Indian Health Service, a tribal health program or urban Indian health program, or through referral of one of these? ☐ Yes ☐ No



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STEP 2: Additional Family Member

Continue with your additional family member.

23. Will PERSON 2 file a federal income tax return the next time taxes are due? *Person 2 can still apply for coverage even if he/she doesn't file a federal income tax return.*

☐ YES. If yes, please answer questions a–d. ☐ NO. If no, skip to question d.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, write name of spouse: _____

b. Will PERSON 2 claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Do any of your dependents live outside of your household? ☐ Yes ☐ No

If yes, list the names of dependent(s): _____

d. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is Person 2 related to the tax filer? _____

24. Is PERSON 2 a primary caregiver to a child under age 19? ☐ Yes ☐ No

If yes, to who? _____ What is their relationship to PERSON 2? _____

25. Does PERSON 2 have Medicaid in another state? ☐ Yes ☐ No

If yes, what state? _____ When will PERSON 2's Medicaid in this state end? _____ (mm/dd/yyyy)

26. Is PERSON 2 pregnant? ☐ Yes ☐ No

If yes, how many babies are expected during this pregnancy? _____ What is their due date? _____ (mm/dd/yyyy)
It's ok to tell us an approximate date if you're not sure.

27. Is PERSON 2 enrolled in, or entitled to enroll in Medicare Part A or B? ☐ Yes ☐ No

28. Has PERSON 2 experienced an emergency health problem and needs help paying for those emergency services? ☐ Yes ☐ No

29. Is PERSON 2 younger than 26 and was in foster care at age 18 or older and lived in Tennessee at that time? ☐ Yes ☐ No

30. Is PERSON 2 under age 65 and getting treatment now or do they need treatment for breast or cervical cancer? ☐ Yes ☐ No

31. Do you live in a nursing home? ☐ Yes ☐ No

If yes, what is the name of the facility? _____

32. Do you need hospice care? ☐ Yes ☐ No

33. Are you over age 65 or are you an adult with physical disabilities and do you want to receive Home and Community Based Services (HCBS)? ☐ Yes ☐ No

What if you think you need care at home to keep from going into a nursing facility? Call your Area Agency on Aging and Disability at 866-836-6678. You still need to finish this application but they can help you.

34. Do you have intellectual or development disabilities and want care at an intermediate care facility for individuals with Intellectual Disabilities (ICF/IID)? ☐ Yes ☐ No

35. Do you have intellectual and/or other developmental disabilities and want to receive Home and Community Based Services (HCBS) and participate in Employment and Community First CHOICES? ☐ Yes ☐ No

What if you think you need care at home to keep from going into a nursing facility? Then you must also complete an online referral at: <https://tcreq.tn.gov/tmtrack/ect/index.htm>.

36. Do you have Medicare and want to get or keep help paying Medicare cost sharing like QMB or SLMB? ☐ Yes ☐ No

37. Did you receive Supplemental Security Income, or SSI benefits, in the past but don't now? ☐ Yes ☐ No

If yes, when did it end? _____

38. Do you have expenses for things to help you work because you are blind or disabled? ☐ Yes ☐ No



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STEP 2: Additional Family Member

Current Job & Income Information

Current job & income information

☐ **Employed:** If PERSON 2 is currently employed, tell us about their income. Start with question 39.

☐ **Not employed:**
Skip to question 49.

☐ **Self-employed:**
Skip to question 50.

Current job 1:

39. Employer name

a. Employer address

b. City

c. State

d. ZIP code

40. Employer phone number

41. Wages/tips per pay period (before taxes)

\$

42. How often do you get paid?

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Hourly | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly |
| <input type="checkbox"/> Every 2 weeks | <input type="checkbox"/> Twice a month | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Yearly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Irregularly |
| <input type="checkbox"/> Semi-annually | <input type="checkbox"/> One Time only | |

43. Average hours worked each pay period. (Answer only if you checked the box for Hourly in question 42.)

Current job 2: (If PERSON 2 has additional jobs and need more space, attach another sheet of paper.)

44. Employer name

a. Employer address

b. City

c. State

d. ZIP code

45. Employer phone number

46. Wages/tips (before taxes)

\$

47. How often do you get paid?

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Hourly | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly |
| <input type="checkbox"/> Every 2 weeks | <input type="checkbox"/> Twice a month | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Yearly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Irregularly |
| <input type="checkbox"/> Semi-annually | <input type="checkbox"/> One Time only | |

48. Average hours worked each pay period. (Answer only if you checked the box for Hourly in question 47.)

49. **Other income you get this month:** Check all that apply, and give the amount and how often PERSON 2 gets it.

☐ None

☐ Unemployment _____ How often? _____

☐ Pensions \$ _____ How often? _____

☐ Social Security \$ _____ How often? _____

☐ Child Support \$ _____ How often? _____

☐ Retirement Accounts \$ _____ How often? _____

☐ Alimony received \$ _____ How often? _____

☐ Net farming/fishing \$ _____ How often? _____

☐ Net rental/royalty \$ _____ How often? _____

☐ Veteran Benefits
Type _____ How often? _____

☐ Other income
Type _____ How often? _____

50. If PERSON 2 is self-employed answer questions a-c.

a. What does PERSON 2 do? _____

b. What type of self-employment does PERSON 2 have? _____

c. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month? \$ _____



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STEP 2: Additional Family Member

Continue to tell us about your additional family member

51. Does someone other than a parent (if under 18) or spouse help pay for PERSON 2's food OR housing each month? ☐ Yes ☐ No

If **yes** answer questions a-e.

a. Does the person who helps PERSON 2 pay for this live with PERSON 2? ☐ Yes ☐ No

b. What do they help PERSON 2 pay for? _____

e. How much does the other person pay? \$ _____

c. How much is this expense or bill? \$ _____

f. How many people are in the home? _____

d. How much does PERSON 2 pay? \$ _____

52. Does PERSON 2 have medical or dental bills for care you've received or paid in the last 90 days? Yes ☐ No ☐

53. Does PERSON 2 have shelter or utility expenses, dependent care expenses, or child support expenses? ☐ Yes ☐ No

54. Do you have before tax deductions? ☐ Yes ☐ No If **yes**, check all that apply. Give the amount you pay each month. If no, skip to question 55.

☐ Medical Insurance \$ _____ Per Month

☐ Deferred Compensation \$ _____ Per Month

☐ Dental Insurance \$ _____ Per Month

☐ Pre-Tax life insurance premiums \$ _____ Per Month

☐ Vision Care Insurance \$ _____ Per Month

☐ Other Deduction Type \$ _____ Per Month

☐ Flexible Spending Account (Health and dependent plans) \$ _____ Per Month

55. Does PERSON 2 have expenses that can be deducted on an income tax return? ☐ Yes ☐ No If **yes**, check all at apply. Give the amount that PERSON 2 pays each month. If no, skip this question.

☐ Alimony Paid \$ _____ Per Month

☐ Health Savings Account Deduction \$ _____ Per Month

☐ Student Loan Interest Paid \$ _____ Per Month

☐ Moving Expense \$ _____ Per Month

☐ Tuition and Fees \$ _____ Per Month

☐ Other Deduction Type \$ _____ Per Month

☐ Educator Expenses \$ _____ Per Month

☐ Business Expenses \$ _____ Per Month

☐ Deductible part of self-employment \$ _____ Per Month

Thanks! This is all we need to know about this Additional Family Member!

After you finish telling us about each person in your family, send in these pages with the rest of your Application.



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